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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

Case No. 800-2017-036123

JONATHAN DAVID RAND, M.D.
4644 Lincoln Blvd Ste 113
Marina Del Rey, CA 90292

A C C U S A T I O N

**Physician's and Surgeon's Certificate
No. G 37418,**

Respondent.

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 17, 1978, the Medical Board issued Physician's and Surgeon's Certificate Number G 37418 to Jonathan David Rand, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2020, unless renewed.

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1 (c), of the Code in that he committed repeated negligent acts in his care and treatment of Patient

2 1. The circumstances are as follows:

3 8. At all times relevant to the charges herein, Respondent was a licensed physician and
4 surgeon practicing internal medicine.

5 9. Patient 1 was a forty-three-year-old male when he first treated with Respondent in
6 June 2004. His medical history included hypertension and headaches.

7 10. On or about November 29, 2011, Patient 1 presented with dizziness and headaches.
8 Respondent believed the dizziness could be attributed to Patient 1's blood pressure medication.
9 Respondent changed the blood pressure medication and prescribed tramadol and Vicodin for the
10 headaches. Respondent claimed he instructed Patient 1 to try tramadol first because it was less
11 potent, and if that did not work, to take the Vicodin.

12 11. Approximately three weeks later, on or about December 22, 2011, Respondent
13 returned for follow-up, still complaining about headaches. Respondent believed anxiety played a
14 role in the headaches and started Patient 1 on Ativan because it had helped him in the past.
15 Respondent prescribed another 30 tablets of Vicodin as well as Ativan 1 mg (30 tablets). The
16 progress note indicated that Patient 1 was planning to see neurology the following week.

17 12. When Patient 1 returned on March 2, 2012, he told Respondent he was seeing a
18 behavioral therapist instead of a neurologist. Because he was still complaining of anxiety,
19 Respondent prescribed Celexa. On or about May 4, 2012, Patient 1 returned for follow-up
20 indicating that the Celexa did not help. Respondent was given refills for Vicodin (60 tablets) and
21 Ativan (60 tablets).

22 13. On or about June 8, 2012, Patient 1 continued to complain of anxiety, headaches, and
23 back pain. He was now taking Vicodin three times per day. Respondent wrote a new prescription
24 for Vicodin (90 tablets) and refilled Ativan (60 tablets). These same medications were refilled on
25 October 19, 2012.

26 14. At the next visit, on or about February 5, 2013, Respondent refilled Vicodin (90
27 tablets) and Ativan was increased to 2 mg. These prescriptions were refilled at Patient 1's final
28 visit with Respondent on May 23, 2013.

1 15. On or about June 2, 2013, Patient 1 was found deceased at his residence. The
2 coroner's medical report indicated the cause of death to be "effects of hydrocodone and ethanol."

3 16. At the time Respondent treated Patient 1, the standard of care for prescribing
4 controlled substances provided that a treatment plan should state objectives by which the
5 treatment plan could be evaluated, such as pain relief and/or improved physical and psychosocial
6 function, and indicate if any further diagnostic evaluations or other treatments were planned. The
7 physician should tailor pharmacological therapy to the individual medical needs of each patient.
8 Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is
9 complex or is associated with physical and psychosocial impairment.

10 17. At the time Respondent treated Patient 1, the standard of care provided that a
11 physician should discuss the risks and benefits of the use of controlled substances and other
12 treatment modalities with the patient, caregiver, or guardian.

13 18. At the time Respondent treated Patient 1, the standard of care provided that a
14 physician should periodically review the course of pain treatment and any new information about
15 the etiology of the pain or the patient's state of health. Continuation or modification of controlled
16 substances for pain management therapy depends on the physician's evaluation of progress
17 toward treatment objectives. If the patient's progress is unsatisfactory, the physician should
18 assess the appropriateness of continued use of the current treatment plan and consider the use of
19 other therapeutic modalities.

20 19. At the time Respondent treated Patient 1, the standard of care provided a physician
21 should keep accurate and complete records, including the medical history and physical
22 examination, other evaluations and consultations, treatment plan objectives, informed consent,
23 treatments, medications, rationale for changes in the treatment plan or medications, agreements
24 with the patient, and periodic reviews of the treatment plan.

25 20. Respondent's care and treatment of Patient 1, as set forth above in Paragraphs 8
26 through 14, includes the following acts and/or omissions which constitute repeated negligent acts:

27 a. Respondent failed to document a treatment plan.

28 b. Respondent was unaware of controlled substance prescribing guidelines that

- 1 had been available for 8 to 10 years.
- 2 c. Respondent failed to document a discussion of the potential side effects of the
- 3 controlled substances he prescribed.
- 4 d. Respondent failed to assess the appropriateness of continued use of Vicodin and
- 5 Ativan, and failed to monitor for compliance with treatment.
- 6 e. Respondent failed to keep accurate and complete medical records.

7 21. Respondent's acts and/or omissions as set forth in Paragraph 20, above, whether

8 proven individually, jointly, or in any combination thereof, constitute repeated negligent acts

9 pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

10 **SECOND CAUSE FOR DISCIPLINE**

11 **(Failure to Maintain Adequate and Accurate Records)**

12 22. Respondent's license is subject to disciplinary action under section 2266 of the Code

13 in that he failed to maintain adequate and accurate records of his care and treatment of Patient 1.

14 The circumstances are as follows:

15 23. Complainant refers to and, by this reference, realleges the allegations set forth in the

16 First Cause for Discipline, as though set forth fully herein.

17 24. Respondent's care and treatment of Patient 1 as set forth in Paragraph 23, above,

18 constitute failure to maintain adequate and accurate records.

19 **PRAYER**

20 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,

21 and that following the hearing, the Medical Board of California issue a decision:


- 22 1. Revoking or suspending Physician's and Surgeon's Certificate Number G 37418,
- 23 issued to Jonathan David Rand, M.D.;
- 24 2. Revoking, suspending or denying approval of Jonathan David Rand, M.D.'s authority
- 25 to supervise physician assistants and advanced practice nurses;
- 26 3. Ordering Jonathan David Rand, M.D., if placed on probation, to pay the Board the
- 27 costs of probation monitoring; and

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4. Taking such other and further action as deemed necessary and proper.

DATED:
January 7, 2019


KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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